SOUTH CAROLINA DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS

REPORT

CONSUMER CONCERNS/COMPLAINTS

I. PERSON MAKING CONTACT:_____

ADDRESS:_____

PHONE NO:_____ DATE:_____ TIME:_____

INDIVIDUAL'S NAME, LOCATION, PROGRAM, ETC.:

_____

_____

_____

CONCERN/COMPLAINT:_

_____

_____

_____

_____

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_____

_____

PERSON CONTACTED:___

LOCATION:_____ PHONE:_____

II. PERSON ASSIGNED RESPONSE:___

DUE DATE:_

FOLLOW-UP REPORT/ACTION:_

_____

_____

_____

_____

_____

_____

III. NOTIFICATION OF APPROPRIATE PERSONNEL

	To be notified (Check)		Initial Report (Date)	Final Report (Date)
REGIONAL DIRECTOR	_____	_____		_____
FACILITY DIRECTOR	_____	_____		_____
STATE DIRECTOR	_____	_____		_____
EXECUTIVE DIRECTOR	_____	_____		_____
OTHER (LIST)	_____	_____		_____
	_____	_____		_____
	_____	_____		_____

DATE:_____ SIGNATURE:_____